Exhibit 4

02/03/2011 02:13 PM 1383E_47067

WORKNET Occ Med-Roxborough
5800 Ridge Ave., Ste. 234
Philadelphia, PA 19128
(215) 487-4540 FAX: (215) 487-4544

Supplemental Charting Notes

Patient Name: Anderson, Dekeshia
Employer: KenCrest Services
Case Number: 2010-00016
Visit Date: 1/14/2011
ICD9 code: 920 Contusion Of Face-Scalp & Neck-Except Eye(s)

Birth Date: 10/16/1972
Injury Date: 12/22/2010

Charting: **WORKNET OCCUPATIONAL MEDICINE** **ROXBOROUGH**

NAME DEKESHIA ANDERSON	DATE OF INJURY 12/22/2010
SS# 200545229	DATE OF SERVICE 01/14/2011
DOB	EMPLOYER KENCREST SERVICES

SUBJECTIVE: This is a followup visit for Ms. Anderson who is being seen for injuries sustained to her neck, her back, and her shoulder on the right side on 12/22/2010. In discussion with the patient she states that she is feeling better, and she is ready to go back to work. She is having relatively no pain with her shoulder or neck anymore. She states that she feels that the physical therapy has been wonderful and that she would like to complete her script for physical therapy. When asked about how much better between 0 to 100% where 100% is before the injury and 0% is right after, the patient states that she is 90% or greater better. She states that she is not taking any medications at this time. She has stopped taking the Tylenol and as discussed prior she has allergies to the nonsteroidal anti-inflammatory drugs and is not taking any of those. She did not take any Flexeril because that was not working as well. The patient states that she feels like she is able to carry things, and the only limitation she has at this point with her right shoulder is when she reaches behind. She is only able to reach partly behind compared to her left shoulder. On further questioning with the patient she denies having any upper extremity musculoskeletal issues such as pain or weakness. She also denies any numbness or tingling, loss of sensation, or heaviness in her upper extremities bilaterally. In her lower extremities she denies having any weakness, numbness, tingling, loss of sensation, heaviness, or pain. No change in her bladder or bowel function. She is not having any nausea or vomiting or any responses from the medications as well.
HISTORY: Review of the patient's brief history report shows that she has just recently seen her primary care physician for a physical. She states there have been no changes to her past medical history, surgical history, family and social history, and each thing was reviewed and the changes that needed to be made were made to her record within her brief history report.
REVIEW OF SYSTEMS: She was found to be negative for GU, GI, neurological, and musculoskeletal systems as well as her general overall health unless stated in the prior pertinent positives and negatives.
PHYSICAL EXAMINATION:
VITAL SIGNS: Blood pressure 112/80, pulse 68, respirations 16.
GENERAL: Ms. Anderson is an obese African American female who appears younger than her stated 38 years old. She is pleasant and responds appropriately to questions. She has a normal affect and disposition. She is alert and oriented to person, place, and thing. The patient is walking with a normal gait and appears to have normal coordination. She moves throughout the room without any difficulty. She sits to stands and stands to sits without any hesitation or difficulty as well. The patient is also noted to step up and hoist herself onto the exam table without any problems.
NECK/CERVICAL SPINE EXAM: Normal size and shape without any swelling or ecchymosis. The skin is warm, dry, without cyanosis, and without edema. There is no spasm or shift. There is no spasm or tenderness to the right or left trapezius area either. There is no tenderness noted throughout. There is full range of motion on flexion, extension, rotation, and right and left lateral extension. There is normal muscle tone. There are normal carotid pulses and no cervical lymphadenopathy. The spine appears to be stable, with no laxity and full strength. There is no radiation into the upper extremities or down the spine.
RIGHT SHOULDER: Normal size and shape without any swelling or ecchymosis. The skin is warm, dry without cyanosis and without edema. There is no tenderness to palpation at this time with this examination. There is full range of motion on lateral and anterior lift. There is full internal and external rotation. The patient is noted to have restricted motion when she reaches

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RIGHT SHOULDER: (Continued)
with internal rotation and posteriorly her hand towards her back reaches the mid spine of her lumbar section versus her left shoulder which goes across to the right flank. There is no pain on impingement testing. There seems to be normal muscle tone throughout the shoulder and normal strength as well.
UPPER EXTREMITY EXAM: Warm, dry, without cyanosis, and without edema. There is normal circulation with normal pulses and normal capillary refill. Normal neurological exam with normal reflexes of +3 throughout. Sensation is normal throughout for light touch. There is normal muscle tone, normal range of motion, and normal stability through all the joints. There is normal strength on resisted flexion and extension of the elbows as well as manual grip testing. Unless stated above in the paragraphs prior.
LOWER EXTREMITY EXAM: Warm, dry without cyanosis and without edema. There is normal circulation with normal pulses and normal capillary refill. Neurological exam shows normal reflexes of +3 throughout. There is no clonus. Straight leg raise to 90 degrees bilaterally. Strength is equal bilaterally at 5/5 for quad and hamstring testing as well as dorsiflexion and plantarflexion at the ankle. Sensation is normal throughout for light touch. There is normal muscle tone, normal range of motion, and normal stability throughout.
IMPRESSION:
1. Neck strain and sprain now resolved.
2. Right shoulder contusion and sprain and strain now resolved up to greater than 90%.

PLAN: The patient is able to be discharged to return to work full duty. She will be discharged from our practice. She was told that she should continue doing the exercises for her shoulder and her neck and make them a habit to maintain the health of her neck and arms. She was also told that she could continue going to physical therapy without any issues and finish out the script that she has for this next week. The patient was told that if anything should happen where she feels that the pain is related to the injury which she had she should follow up again with us. Otherwise she is being discharged as stated above.

	JN: 02837648	DN: 00096308
Francine Katz, D.O. FK/62	DD: 01/14/2011 09:54:00	TD: 01/17/2011 09:31:00

Dictated but not read unless signed.